... MassMutual Ascend

Life Insurance Company

Affiliate:

Annuity Investors Life Insurance Company®

Administrator for:

Loyal American Life Insurance Company®

Fixed & Fixed Indexed Annuities: PO Box 5420, Cincinnati OH 45201 / 800-854-3649 / 800-482-8126 Fax Registered Index-Linked Annuities: PO Box 5423, Cincinnati OH 45201 / 800-789-6771 / 800-807-9777 Fax

Variable Annuities: PO Box 5423, Cincinnati OH 45201 / 800-789-6771 / 513-768-5115 Fax

Overnight Address: 191 Rosa Parks St, Cincinnati OH 45202

STATEMENT OF CLAIM LONG-TERM CARE CONFINEMENT & TERMINAL ILLNESS REQUESTS

	Contrac	Contract/Certificate Number		
Name of Owner(s)	Social S	ecurity No/Tax Id No	Daytime Phone	
Address			1,	
Name of Annuitant/Participant (if different)	Social S	ecurity No		
Instructions	'			
 Complete this side of form only. Please answer The attending Physician must complete and sign Forward completed form to the appropriate address 1. Claim Type	the reverse side	of this form.	n to release information.	
☐ Long-Term Care Waiver 2. Medical Information		Terminal IIIness	Rider	
Please describe in detail the nature of your illness,	injury, or disabilit	y:		
Date of Admittance to Long-Term Care Facility or H	lospital (if applica	able)		
Name/Address/Contact information for Facility (if ap	oplicable):			
Name of Attending Physician				
3. Distribution Type (Note: additional forms for	or each option AF	RE needed. Contact N	MassMutual Ascend or Affiliate.)	
☐ Full Surrender ☐ Annuity Payout Benefit/Settlement Option	n Election ⁽¹⁾	Partial Surrer Easy Systema	nder atic Payment Program ⁽¹⁾	
4. Authorization to Release Information I hereby authorize any Qualified Long-Term Care F MassMutual Ascend or Affiliate or its representative.	Facility, Hospital	or Physician to relea	ase any information requested b	
Signature of Annuitant	Date	Signature of Owner	(if different) Date	

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD OR DECEIVE ANY INSURANCE COMPANY, FILES A STATEMENT OF CLAIM CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION, MAY BE GUILTY OF A CRIMINAL ACT PUNISHABLE UNDER LAW. MASSMUTUAL ASCEND OR AFFILIATE DO NOT WAIVE ITS RIGHT TO INVESTIGATE ANY CLAIM AND TO TAKE APPROPRIATE ACTION BASED ON SUCH INVESTIGATION. YOU ARE ENTITLED TO APPEAL ANY DENIAL OF A CLAIM. A WRITTEN APPEAL MUST BE MADE WITHIN 30 DAYS OF RECEIPT OF THE DENIAL.

⁽¹⁾This distribution type is only available for Long-Term claims.

PHYSICIAN'S STATEMENT

I. P	atient Information		
Patie	ent's Name:		
	Last Name	First Name	MI
Patie	ent's Account Number		
Date	patient first consulted you for this condition:		
Diag	nosis of illness, injury, or disability:		
	s illness, injury or disability expected to confine to bital permanently?	he patient to this or any oth	er Qualified Long-Term Care Facility or
	YES Please complete this information as reque	ested below:	
	Date of Admittance to Facility or Hospital		
	Name and Address of Facility or Hospital where	e patient is confined	
	NO Please describe in detail:		
	e duration of the terminal illness indicated in Sector of diagnosis?	tion 1 expected to result in	death within twelve (12) months of the
	Yes ☐ No ☐ Not Applicab	ole	
No	te: Some terminal illness riders may allow a clain expectancy is longer than 12 months from the	=	
2. P	hysician's Information	- '	
Nam	е	Office Phone Num	nber
Addr	ress		
City/	State/Zip		
3. P	Physician's Certification		
	Physician's Signature	Date	

"Long-Term Care Facility" is defined as a Skilled Nursing Facility, Intermediate Care Facility or Hospital, which is located in the United States or its territories, and is licensed and operates as such according to the laws of the jurisdiction in which it is located; provides continuous, 24 hour a day nursing services by, or under the supervision of a licensed physician, a registered graduate professional nurse (R.N.), or a licensed practical nurse (L.P.N.); and maintains a daily medical record of each patient. "Long-Term Care Facility" does not mean: a place that primarily treats drug addicts or alcoholics; a home for the aged or mentally ill; a community living center, or a place that provides domiciliary, residency or retirement care; or, a place owned or operated by a member of the Annuitant's immediate family (including any spouse, children, parents, grandparents, grandchildren, siblings, or in-laws of the Annuitant).

"Hospital" is defined as a facility which: is located in the United States or its territories; is licensed as a hospital by the jurisdiction in which it is located; is supervised by a staff of licensed physicians; provides nursing services 24 hours a day by or under the supervision of, a registered nurse (R.N.); operates primarily for the care and treatment of sick and injured persons as inpatients for a charge; and has access to medical, diagnostic and major surgical facilities.

"Physician" is defined as a licensed medical doctor (M.D.), or a licensed doctor of osteopathy (D.O.) practicing within the scope of his or her license. The term "Physician" does not include the Annuitant, or a member of the Annuitant's immediate family.